ILLINOIS DEPARTMENT OF Healthcare and Family Services

Prior Authorization Request Form
Cubicin, Synercid, Tygacil, or Zyvox

Identification Information

Patient Information (required):

Name:_____

DOB:_____

Nine-Digit IDHFS ID Number:_____

LTC Facility Information (if applicable):

Facility Name:_____

Phone:_____

Fax:_____

Physician Information (required):

Name:_____

Phone:_____

Fax:_____

State License #:_____

Pharmacy Information (if available):

Pharmacy Name:_____

Phone:_____

Fax:_____

HFS Provider #:_____

Clinical Information

1. Medication (circle one): **Cubicin** **Synercid** **Tygacil** **Zyvox**

   Requested Dose:_____ Route: IV or PO Schedule:_____ Duration:_____
2. Is this a renewal request? ☐ Yes ☐ No
3. Does the patient have IV access at home? ☐ Yes ☐ No
4. (**For Zyvox only**) Is oral therapy appropriate for this patient? ☐ Yes ☐ No

   If not, please explain:_____
5. Does the patient have any allergies? (Please check all that apply)

   ☐ penicillin ☐ sulfa ☐quinolone ☐ tetracycline ☐ vancomycin ☐ other: _____

   Describe the reaction: _____
6. List any other antibiotics that have been tried for this infection:_____
7. Type of Organism: _____

   Type of infection:_____ Location of infection: _____

   (An attached copy of the most recent culture and sensitivity report is required)
8. Requesting physician's name: _____

   Specialty: ☐ Infectious Disease ☐ Critical Care ☐ Surgery ☐ Other:_____

   Contact Number:_____

Additional Information:_____

_____

Physician or designee's signature:_____ Date:_____

Please complete form and fax to 217-524-7264
For more information please call 1-800-252-8942